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TAGS: ECON EFIN TH
SUBJECT: UNIVERSAL HEALTH CARE MENDING BONES BUT BREAKING BUDGETS

¶1. Summary: Thailand's universal health care system introduced by caretaker PM Thaksin has earned broad popularity among the Thai public. However, it has faced heavy criticism for being chronically underfunded, forcing public hospitals to cut back on service and placing numerous hospitals into the red and facing the possibility of bankruptcy. At the same time, the expanding costs of the program are fueling fears that the RTG health budget will be overstretched and bring the entire health care system crashing down with it. Although health care costs are rising as a share of the national budget, analysts are confident that with the expanding economy and concomitant tax revenue, the national budget can handle the cost and that the program's popularity will eventually translate into fuller funding. End summary.

Shot in the arm to Thai health, but a pain in the budget

¶2. In 2001, following on the campaign promises of newly elected PM Thaksin, Thailand embarked on a universal health care coverage system requiring a co-payment of only 30 baht (75 cents) for virtually any medical treatment, including medicines. The 30 Baht program, as it came to be known, has been hugely popular among the Thai public, particularly among the millions of previously uninsured who had rarely made use of the health care system and often were plunged into heavy debt when catastrophic illness struck.

¶3. Over 48 million Thais are covered by the universal coverage (UC) system. The Civil Servant benefit scheme and Social Security scheme cover much of the rest of Thailand's 64 million citizens, with private insurance covering those who can afford it. The UC system is paid for out of the general budget and administered by the semi-independent National Health Security Office (NHSO). Hospitals receive a monthly transfer from the NHSO based on the number of registered beneficiaries in their area, multiplied by the "capitation rate", an amount the RTG determines annually based on NHSO's projections of health care costs required per person under the program. For FY 2006 the rate was set at 1659 baht (USD 44), with some adjustments for salaries and other factors. The system is dominated by the country's public hospitals (few private hospitals chose to join), which are expected to manage their own books and cover their costs.

¶4. The lifeblood of the UC system is the capitation payments to hospitals. At the outset of the UC program in 2001, Ministry of Public Health (MoPH) analysts projected a capitation rate of 1200 baht would be sufficient to cover costs, basing their analysis on a 1996 survey that outlined costs and use of the health care system. However, hospital visits boomed under the new program, and the NHSO quickly

recognized that they had seriously underestimated the initial cost projections.

¶5. Although the RTG has steadily increased the capitation rate over the past few years, the annual increases are consistently below NHSO requests. In what has become a recurring theme, NHSO recommendations for increases are mostly ignored as the RTG shows a strong preference for low end cost projections and lower capitation rates to ease budget pressure. For FY 2005, NHSO calculated that a rate between 1732 and 1510 baht would be necessary to meet costs depending on a number of economic factors; the government instead offered 1396. FY 2006 saw an increase to 1659 baht, though independent researchers felt the number should be closer to 2000 baht per head to meet hospital costs.

Hospitals on life support

¶6. The general consensus among health care analysts is that the UC program is underfunded as a whole and critically so in certain areas of the country. Out of 800-odd public hospitals nationwide, approximately 200 are estimated to be operating in the red, mostly those in the relatively poorer Northeast region. Financing reform early in the program focused on redistributing resources to deprived areas on a more equal basis, and under-staffed rural hospitals in highly populated areas benefited. However, the budget allocation later changed in favor of larger hospitals, leaving some district hospitals with a smaller per capita budget than before the UC program. The overall budget was insufficient to meet costs under the program, and within two years hospitals of all sizes were in deep debt. A contingency fund of five billion baht (USD 120 million) was set up to bail out

hospitals with severe financial difficulty, but the fund was nearly exhausted after only one year.

¶7. The current discrepancy between total costs and the UC budget has narrowed, but hospitals say the budget is insufficient to maintain the level of quality of health care. Hospitals complain that the annual increases in the capitation rate fail to keep up with inflation and rising health care costs, including doctor salaries and prices of medicines. Despite the stresses put on the health care system, the UC system has yet to bankrupt a hospital and most are surviving if not thriving. As Dr. Viroj Naranong, a health care researcher at the influential Trade and Development Research Institute (TDRI), put it, "they survived on 1396 baht, they'll survive on 1659." NHSO has asked for 2059 baht for FY 2007, an amount that if approved promises to reduce much of the financial handwringing.

Thaksin the CEO manages costs

¶8. Dr. Viroj placed much of the blame for the underfunding on caretaker PM Thaksin. After taking office Thaksin focused on maintaining economic growth and keeping taxes low, and forced the UC program to compete for funds like every other government program. Says Viroj, "Thaksin didn't dispute the NHSO analysis on capitation rates, he just didn't have the money." However, Viroj speculated that financial constraints were not the only reason for the underfunding and suggested that the MoPH deliberately set the capitation rate below actual costs in order to force cost-saving management reforms throughout the health care system.

¶9. Health care, and the UC system in particular, is an increasing share of the national budget, but analysts are confident the national budget can handle the extra weight of the UC program. For FY 2006, the UC program will cost the RTG approximately 81 billion baht (USD 2.1 billion), approximately 5.5 percent of the national budget. In an era of economic growth and increasing government revenues, TDRI's

Dr. Viroj felt the RTG had the wherewithal to fully fund it. However, Viroj predicted that the government would wait until the program was in serious financial danger before coming to the rescue with more funds. In a recent tiff between the Ministry of Public Health and TDRI, former TDRI President Ammar Siamwalla claimed the RTG had sufficient funds to fully fund the UC program but had chosen not to, and accused Thaksin of neglecting the UC program in favor of other spending more likely to earn votes in the most recent election.

Putting hospitals on the road to recovery

¶10. Faced with shortfalls in operating budgets, hospitals are tightening up management and cutting back on immediate nonessentials, most notably capital investment. For FY 2006's capitation rate of 1659 baht, NHSO budgeted 100 baht for capital expenditure, but TDRI estimates hospitals are utilizing only 40 baht for this purpose. A separate study by TDRI estimated that capital expenditures of 200-300 baht per head would be necessary to maintain an acceptable level of capital replacement and modernization. Most hospitals have deployed other cost-saving strategies as well, using more generic and locally produced medicines instead of imported brand name drugs, trimming preventive medicine programs, overtime staff, and other non-medical care expenses. More drastically, hospitals in serious financial trouble have found that reducing and refusing service to patients often brings a chorus of complaints to government officials and a quick infusion of funds from the central government.

¶11. Doctors at public hospitals have bridled at the extra workload brought in by the UC scheme and defections to private hospitals are common. As it reduced the financial barrier to medical care, the UC program expanded the demand for health services. Use of health care facilities rose by 25% in the first two years of the program, 54% in district hospitals alone. A 2003 poll of health care providers found that more than 70% of healthcare workers claimed that their workload increased due to the UC policy, a particular burden in district hospitals that were already understaffed. Discontent was furthered by widely diverse salaries between public and private hospitals. Despite increased financial incentives for doctors working in public hospitals, including a 20,000 baht (USD 500) bonus for working in rural hospitals, NHSO's Dr. Pongpisut Jongudomsuk said MoPH's eventual goal

was to build public hospital salaries up to 80 percent of private hospital salaries. The UC system has taken the blame for sparking an exodus of doctors to private hospitals, but Dr. Pongpisut noted that Thailand's improving economy enabled private hospitals to afford increasingly higher salaries that public hospitals could not match, a situation that would have existed without the UC program.

¶12. In addition to cutbacks, hospitals have met shortfalls by expanding revenue from other sources. Dr. Vithit Artavatkun, director of Ban Phaew Hospital south of Bangkok, a hospital considered to be a success story for UC, told Econoff that although 80 percent of their patients used the UC program, only 30 percent of their revenue came from the UC budget. To cover the gap, the hospital shifts some of its costs onto the more generous (and less regulated) civil servant scheme. Patients looking for extras, such as private rooms, get to pay out of pocket. Ban Phaew works on community involvement and pockets additional funds from local business and foundations that recognize the contribution the hospital makes to the community. Ban Phaew and other hospitals with specialists and state-of-the-art technology in various treatments have advertised their specialties, attracting patients from outside their area willing to pay out of pocket for better care.

Code Blue) HIV/AIDS and kidney treatment could spike UC

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¶13. The future financial viability of the UC program will be tested by a recent RTG decision to place HIV/AIDS treatment under UC coverage, and plans to expand the system to include kidney transplant and dialysis as well. In October 2005, MoPH committed to providing anti-retroviral treatment to all HIV positive patients who require it, approximately 80,000. Although Thailand produces a cheap, generic anti-retroviral, the drug loses its effectiveness after a number of years and patients must move to more expensive second-line treatments. As Thailand expands the life-saving treatment, the number of patients being treated yearly will only increase and costs could increase exponentially.

¶14. TDRI estimates that adding HIV and kidney treatment would necessitate a substantial increase in the capitation rate. The current budget for HIV treatment is 2.7 billion baht for FY 2006, only about three percent of the UC budget, but an increase in HIV prevalence or a failure to lower costs of antiretrovirals could quickly increase that percentage. For now the MoPH is keeping a separate budget for HIV/AIDS treatment and will create another for kidney treatment, but NHSO says the split is more for psychological reasons, not wanting to appear to be swamping the UC system. A pilot project for kidney dialysis is actually under budget, but primarily because there is a shortage of doctors qualified to provide the treatment.

Financing options to put UC back on its feet

¶15. Concerned that the UC program's funding through general revenues makes it vulnerable to competition for funds between ministries and political manipulation, UC advocates are seeking a stand alone financing mechanism to support the system. The 30 baht co-pay is at the moment the only source of independent funds, but makes up only two percent of revenues for hospitals from the UC program. NHSO staff are somewhat wistful that the UC program earned the moniker "30 Baht program", making it that much more difficult to increase the level of co-payment.

¶16. A recent study by the International Health Policy Program (IHPP) recommended generating revenue for the UC program by raising "sin taxes", earmarking two-thirds of additional tobacco tax revenues and half an increase in excise tax on alcohol and beer. TDRI's Dr. Viroj supported the idea of a separate fund, but questioned the wisdom of relying on revenue that fluctuates with economic conditions, noting that revenue from sin taxes dropped significantly during the 1997-8 financial crisis. IHPP proposed also that the Social Security system, which relies on employer and employee contributions as well as government funds, be widened to include non-working spouses and dependents of SS recipients, taking six million people off the UC rolls. IHPP also recommended that a premium on auto insurance be transferred to the NHSO to cover the over seven billion baht (USD 190 million) annual cost to the UC system to care for

victims of traffic accidents.

Hospitals hurting, but patients feel better

¶17. Despite the numerous complaints about the administration of the UC program, nearly everyone in the health care field agrees that the program has been a boon to health care in Thailand. WHO's local rep, Dr. William Aldis, pointed to improving infant and maternal mortality statistics, two of the best indicators of how well a health care system is functioning. The use of smaller primary care units in the field (cheaper than tertiary care in hospitals) has improved health in rural areas by improving access. The

December 2004 tsunami that hit Thailand demonstrated the sturdiness of the system. 13,000 patients hit the health care system at the same time, many with massive head trauma and nasty fractures, yet the case fatality rate remained low and no hospitals broke under the strain.

¶18. A recent poll of healthcare professionals rated the quality of services provided to all patients as "good" or "very good", but they ranked the quality provided to UC beneficiaries lower than that provided to Social Security and Civil Service beneficiaries. However, 85 percent of patients surveyed said they were satisfied with the medical services they received under the UC program, and 75 percent said their quality of life in terms of health had improved since the inception of the program in 2001. Only one percent said it had worsened.

¶19. Comment: The UC program is still identified with the ruling Thai Rak Thai party and Thaksin himself, but broad political support among diverse political parties and overwhelming popularity among the Thai public should ensure that the program will continue past Thaksin's tenure as PM. Like other similar systems, the 30-baht policy has stimulated demand while suppressing supply. The dislocation and financial distress that the UC system brought to hospitals has been rough on many, but increasing demands for proper funding promises to put the program on surer footing. The expanding costs of the UC program have taken a sizable chunk out of the national budget, but health officials recognize that the total health expenditure for Thailand (about four percent of GDP) needs to be raised. They see growing expenditures not as a financial threat, but as a worthy investment in improving public health and believe that the time has come for Thai society to accept the necessary financial commitment. End comment.
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